L

University Hospitals

Employee Assistance Program
Conditions of Employment

Compliance Contract

between

Frank Dundee

Employee

and the

Employee Assistance Program Counselor

I understand that my supervisor referred me to the Employee Assistance Program (EAP) as a Mandatory Referral. I understand that my EAP assessment resulted in certain recommendations and I must comply with them.

I understand that my compliance with the EAP attendance recommendation and treatment plan must be monitored as determined by the EAP counselor. If I do not comply with the recommendation and/or treatment plan within ____ week (s) my supervisor and /or HR will be informed. Non-compliance may result in corrective action up to and including discharge.

The EAP recommendation/treatment plan requirements are as follows: attend evaluation with Warren Rubin Ph.D follow recommendations. Follow-up with EAP as scheduled.

I understand and agree to comply with the conditions of this Contract.

[signature] 7-26-17

Employee Date

[signature] LPCC 7/26/17

EAP Counselor Date

ATTACHMENT A

Authorization for Release of Medical Information

University Hospitals

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from:

Cleveland Medical Center ☐ Ahuja ☐ Bedford ☐ Conneaut ☐ Geneva ☐ Geauga ☒ Richmond ☐ UH Home Care ☐ UHPS ☐

Patient Name (Please Print) Dulbee Frank
Last First MI

Date of Birth 3-17-53 Social Security Number (last four digits)

Address 7707 Underwood Tr Bainbridge, OH

Phone Number (330) 226-2602

Medical Record Number

Prior MR #

Treatment Date(s) 7-26-17

Please Release Medical Information to the Following Recipient: Warren Salten, Ph.D.

Name of Person or Organization ________ Phone #

Address ________ Mailstop

Fax #

City State Zip Code

Purpose of Disclosure Evaluation

Description of Information to be Released:

☐ Pertinent Summary includes all items

☐ Admission Form	☐ Facesheet / Demographics	☐ Physical Therapy
☐ Discharge Summary	☐ Lab Reports	☐ Entire Record
☐ Emergency Room Report	☐ Radiology Report	☐ Physician's Notes
☐ History & Physical	☐ EKG Report	☐ Other ________
☐ Consultation Report	☐ Pathology Report	
☐ Operative Report	☐ Card Cath Report	

I specifically authorize UH EAP [illegible] to release information from my medical records as described above. I understand that I acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol and/or drug dependence or abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may [illegible] my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition ________. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of information and accept financial responsibility.

x [signature] 7-26-17
Signature of Patient/Legal Representative** Date Signed

☐ Patient unable to sign

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

[illegible]

"HIM13018"

Patient ID Label

GM-61 – Accessing Protected Health Information
Owner: Health Information Management
Revised: March 2017
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Uncontrolled document – printed version only reliable for 24 hours

ATTACHMENT A

Authorization for Release of Medical Information

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from:

Cleveland Medical Center ☐ Ahuja ☐ Bedford ☐ Conneaut ☐ Geneva ☐ Geauga ☒ Richmond ☐ UH Home Care ☐ UHPS ☐

Patient Name (Please Print): DUDEK (Last) FRANK (First) (MI)

Date of Birth: 5-17-53 Social Security Number (last four digits): ____

Address: 7707 [illegible] Dr [illegible], OH

Phone Number: (330) 726-2662

Medical Record Number: ____

Prior MR #: ____

Treatment Date(s): 1-26-17 CP

Please Release Medical Information to the Following Recipient:

Name of Person or Organization: ____ Phone #: ____

Address: ____ Mailstop: ____

Fax #: ____

City ____ State ____ Zip Code ____

Purpose of Disclosure: [illegible] ☐ [illegible]

Description of Information to be Released:

☐ Pertinent Summary, includes all items

☐ Abstract of Record
☐ *Discharge Summary
☐ *Emergency Room Report
☐ *History & Physical
☐ *Consultation Report
☐ *Operative Report

☐ Facesheet, Demographics
☐ Lab Results
☐ *Radiology Report
☐ *EKG Report
☐ *Pathology Report
☐ *Card Cath Report

☐ Physical Therapy
☐ Entire Record
☐ Physician's Notes
☐ Other ____

I, the undersigned, authorize UH EAP (Disclosing Institution) and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

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I understand there may be charges for the copying and release of information and accept financial responsibility.

x [signature: Declined] ____
Signature of Patient/Legal Representative ____ Date Signed

☐ Patient unable to sign

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

[illegible]

HIM13018

Patient ID Label

ATTACHMENT A

Authorization for Release of Medical Information

University Hospitals

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from:

Cleveland Medical Center ☐ Ahuja ☐ Bedford ☐ Conneaut ☐ Geneva ☐ Geauga ☒ Richmond ☐ UH Home Care ☐ UHPS ☐

Patient Name: Dudel (Last) Frank (First) (MI)
Please Print

Date of Birth: 8-17-53 Social Security Number (last four digits) ____

Address: 7707 Amerwood Dr Phone Number: 330-726-2662

Medical Record Number ____

Prior MR # ____

Treatment Date(s): 7-26-17

Please Release Medical Information to the Following Recipient: federal lawsuit

Name of Person or Organization ____ Phone # ____

Address ____ Mailstop ____

Fax # ____

City State Zip Code

Purpose of Disclosure: [illegible] ☐

Description of Information to be Released:

☐ Pertinent Summary [illegible]	☐ Facesheet / Demographic [illegible]	☐ Physical Therapy
☐ Admission Form	☐ Lab Reports	☐ Entire Record
☐ *Discharge Summary	☐ *Radiology Report	☐ Physician's Notes
☐ *Emergency Room Report	☐ *EKG Report	☐ Other ____
☐ *History & Physical	☐ *Pathology Report	
☐ *Consultation Report	☐ *Card Cath Report	
☐ *Operative Report		

I authorize UH EAP [illegible] its successors, affiliates and employees to release information from my health record [illegible] I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

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x [signature] 7-26-17
Signature of Patient/Legal Representative** Date Signed

☐ Patient unable to sign

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable) ____

[illegible]

HIM13018

Patient ID Label

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Records to be released from:

Cleveland Medical Center ☐ Ahuja ☐ Bedford ☐ Conneaut ☐ Geneva ☐ Geauga ☒ Richmond ☐ UH Home Care ☐ UHPS ☐

Patient Name DUNDEE ERNIE
Please Print Last First MI

Date of Birth 5-17-53 Social Security Number (last four digits) ______

Address 7707 Cumberland Dr. Phone Number (330) 726-2662
Boardman, Oh Medical Record Number ______
Prior MR # ______

Treatment Date(s) 7-26-17

Please Release Medical Information to the Following Recipient: Excellence Dispatch
Name of Person or Organization AK Phone # ______
Address ______ Mailstop ______
Fax # ______
City State Zip Code

Purpose of Disclosure ER Compliance, Recommendations

Description of Information to be Released:

☐ Abstract Summary ...
☐ Admission Form ☐ Facesheet ... ☐ Physical Therapy
☐ *Discharge Summary ☐ Lab Reports ☐ Entire Record
☐ *Emergency Room Report ☐ *Radiology Report ☐ Physician's Notes
☐ *History & Physical ☐ *EKG Report ☐ Other ______
☐ *Consultation Report ☐ *Pathology Report
☐ *Operative Report ☐ *Card Cath Report

UH ER

[illegible] ... information regarding psychiatric disorders, Human Immune ... test results, Acquired Immune Deficiency Syndrome (AIDS) ... AIDS-related condition ... authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

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[illegible]

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Owner: Health Information Management
Revised: March 2017
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